



# Ohio Behavioral Health Housing Needs Assessment 2015

## A Statewide Housing Inventory, Resources and Geographic Scan

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### PURPOSE

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has identified safe and affordable housing options as one of its top priorities in meeting the needs of persons living with mental health and addiction issues. OhioMHAS collaborated with the local Alcohol, Drug Addiction and Mental Health (ADAMH), County Mental Health (CMH), and Alcohol, Drug and Addiction Services (ADAS) Boards to launch the 2015 Ohio Behavioral Health Housing Needs Assessment, a comprehensive statewide scan of the housing and support needs of persons affected by mental health or addiction issues in Ohio. The findings are expected to enable OhioMHAS and Board leadership to better prioritize funds, provide a full continuum of housing within the board regions, and to develop comprehensive housing plans in a few actionable areas. They align with the state's legislative mandate that requires housing as a component of the state's continuum of care for persons with behavioral health disorders.

The information in this study was self-reported by local ADAMH, CMH and ADAS Boards. It is not meant to be an exhaustive list of housing resources or needs across Ohio, as it does not include housing funded outside of the local boards. The report summarizes: relevant background information related to Ohio's population and those with behavioral health issues; housing status of individuals with mental health and addiction issues; and current housing inventory (unit/beds) and resources (expenditures) by housing types and geographical entities.

Please view the companion publication, [A Brief Report on Statewide Housing Needs and Wait Time](#).

### DEMOGRAPHICS AND SELECT BEHAVIORAL HEALTH PARAMETERS

An estimated 11.6 million people live in Ohio's 88 counties, which are comprised of large urban areas and small rural agricultural and Appalachian geography. Population density ranges from 35 persons per square mile in Monroe County to 2,140 per square mile in Franklin County (location of the capital city of Columbus). Fifty-eight percent (6.5 million) of the state's population live in low-and-moderate income households and nearly one in five Ohioans is a member of a racial or ethnic minority group; 13% of the population has at least one type of disability; and nearly one in three households were experiencing a housing problem, meaning they are cost-burdened, overcrowded or functionally substandard housing.<sup>1</sup>

1 Select points excerpted and summarized from: Ohio Housing Needs Assessment: Technical Supplement to the Fiscal Year 2016 Annual Plan. Information available at: <https://ohiohome.org/housingneeds14.pdf>. Accessed on August 13, 2015.

#### *Housing and Persons with Behavioral Health Issues*

In Ohio, about 683,000 individuals aged 12 or older (7.1% of all individuals in this age group) per year in 2009–2013 (combined data) were dependent on or abused alcohol within the year prior to being surveyed. With regard to mental illness, about 796,000 adults with Any Mental Illness (AMI) per year in 2009–13 (combined data) received mental health treatment or counseling, which is less than 50% (26.2%) of all adults with AMI.<sup>2</sup> The federal Substance Abuse and Mental Health Services Administration (SAMHSA) report for Ohio also highlighted that about 409,000 adults (4.7% of all adults) per year in 2009–13 had severe mental illness within the year prior to being surveyed. Persons with

2 Substance Abuse & Mental Health Administration (SAMHSA). Behavioral Health Barometer: Ohio, 2014. Available at: [http://www.samhsa.gov/data/sites/default/files/State\\_BHBarometers\\_2014\\_2/BHBarometer-OH.pdf](http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-OH.pdf). Accessed on September 11, 2015.

mental illness and substance use disorders experience high rates of homelessness and unstable housing. Many people with disabilities end up living on the streets, in homeless shelters, or in inaccessible or substandard housing; for others the lack of Permanent Housing results in their remaining in inappropriate institutional settings.<sup>3</sup> According to the Coalition on Homelessness and Housing in Ohio, 13,003 Ohioans were homeless on a single day in 2011; a 24-hour period point-in-time count from Ohio's Continuum of Care found 11,197 homeless individuals (86.1% of the single-day total count) in emergency shelters and transitional housing; of those, 18% were severely mentally ill and 25% were chronic substance abusers.<sup>4</sup>

Many individuals with behavioral health disorders can live successful and productive lives in the community, if appropriate housing were available. Many of these individuals would choose to live independently or in a more structured living environment, if given the chance, but cannot because housing is unaffordable. While the Housing and Urban Development Act has established 30% as the national threshold for household income spent on rent, the average rent for a studio apartment in Ohio currently is 74% of the average Supplemental Security Income (SSI) payment (\$773). This makes housing unaffordable for most adults living with serious mental illness who rely on SSI.<sup>5</sup> Most persons with serious mental illness and many with severe substance use disorders easily fall into Ohio's "worst case housing need," where they pay well over 50% of their income on rent and live in substandard housing.<sup>6</sup> Another factor making housing difficult for persons with behavioral health disorders is the limited availability of renter-occupied housing units. Ohio's rental vacancy rate is 9%, creating a challenge to find affordable rental units.<sup>7</sup> The short supply of specialized housing units for persons with behavioral health disorders becomes a critical issue.

## METHODS

### Participants

The participants of the Ohio Behavioral Health Housing Needs Assessment are ADAMH, CMH and ADAS Boards (hereafter referred to as Board or Boards) in Ohio's publicly funded behavioral health system. The Excel-based survey instrument was emailed to 51 Boards; 45

3 NAMI (National Alliance on Mental Illness). Housing Toolkit. Available at: <http://www.namiohio.org/images/publications/Publications/housingtoolkit.pdf>. Accessed on December 16, 2015.

4 To read the report, visit: <http://www.cohhio.org/files/2011%20Ohio%20Homelessness%20Report%20v13.pdf>

5 NAMI, 2015. Available at <https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Securing-Stable-Housing>. Accessed on December 16, 2015.

6 Housing and Urban Development (HUD), Available at: [http://www.huduser.gov/portal/Publications/pdf/WorstCaseNeeds\\_2015.pdf](http://www.huduser.gov/portal/Publications/pdf/WorstCaseNeeds_2015.pdf). Accessed on December 16, 2015.

7 US Census Bureau, Available at: <http://www.census.gov/housing/hvs/data/rates.html>

Boards responded, thus yielding a response rate of 88.2%. This report is therefore based on 45 Board responses for State Fiscal Year (SFY) 2014 (June 2013-July 2014); the time frame (month of May) set aside for the response did not allow for SFY 2015 (June 2014- July 2015) data to be collected.

### Procedures

During April 2015, OhioMHAS emailed all the Boards a spreadsheet, documents explaining OhioMHAS Housing Categories and Definitions Crosswalk; and OhioMHAS Housing Inventory Instructions. To encourage a higher response rate and ensure accurate data, OhioMHAS hosted a conference call on May 14 and to respond to any questions. The department made additional efforts to collect responses from Boards who were not able to respond by the original deadline (May 27). OhioMHAS compiled the individual Board responses into one consolidated spreadsheet, entered all valid data in summary Excel files, and analyzed the data.

### Measurement

The survey focused on estimating a Board area's current inventory of housing and its housing-related expenditures across these four OhioMHAS-defined housing categories: Residential Treatment, Residential Care, Permanent Housing and Time-Limited Temporary.<sup>8</sup> Current inventory counts were based on the number of beds per category, except for Permanent Housing which in most cases is measured in number of units. (Note that Recovery Residences, a subset of Permanent Housing, are counted in terms of beds.) Total dollars spent were measured by types of expenditure (such as, capital, operations, supports, subsidies and services) across housing categories.<sup>9</sup>

### Analysis

Housing expenditures are analyzed across five resource categories: capital, operations, supports, subsidies and services.<sup>10</sup> Data represents publicly available behavioral health housing services in Ohio for persons aged 18 to 59, as of SFY 2014. A quantitative approach was utilized to analyze the data. Descriptive statistics includes

8 For OhioMHAS Housing Definitions, visit: <http://mha.ohio.gov/Portals/0/assets/Supports/Housing/201407-Housing-Crosswalk.pdf>

9 Unit is defined as a place where a person or multiple people live that has a kitchen, bath, bedroom(s) intended for independent living with standard lease. Beds are simply reported as number of beds for the specific category in the Board area. The units and beds are treated separately (and not as units=X beds) even though in some cases units may directly correspond to the reported number of beds.

10 Five types of expenditures (resources) are: capital (amount spent on capital purchases); operations (amount spent for operations), support (amount spent on services that assist with housing retention that are not necessarily billable by Medicaid; and can include housing support services or recovery supports- such as peer support, front desk staff, resident manager, AA groups, computer lab services etc.); subsidies (funds spent in subsidies, such as rental assistance); services of funds the board has expended in services (funds spent on services that refers to Medicaid billable benefits that includes CPST [Community Psychiatric Supportive Treatment], medical, psychiatry, and medical management services etc.).

percentages. Graphs and summary matrix tables are used to graphically depict the data. Inventory data and expenses were compiled for each category of housing across four geographic entities – suburban, rural, metropolitan and Appalachian communities – with a view to get additional insights on geographic differences in

housing and Board expenditures (Appendices B through E). This analysis does not include multi-county Boards that served two or more entities. Graphs on expenditures (numbers 6 through 9) were created corresponding to each unique housing category and were not created on one uniform scale for all housing categories.

## FINDINGS

### Current Inventory

Statewide inventory of beds as reported by 45 of 51 Boards for three (Residential Treatment, Residential Care and Time-Limited Temporary) of the four housing categories in the public behavioral health system reflects a total of 6,760 beds including 411 beds for Recovery Residence (Permanent Housing); with the Boards spending a total of \$115 million (figure 1). Residential Care housing accounted for close to 52% of the total 6,760 beds, followed by Residential Treatment housing (24%). Permanent Housing, excluding Recovery Residence, had a total of 6,340 units with Board expenditures of \$53 million.

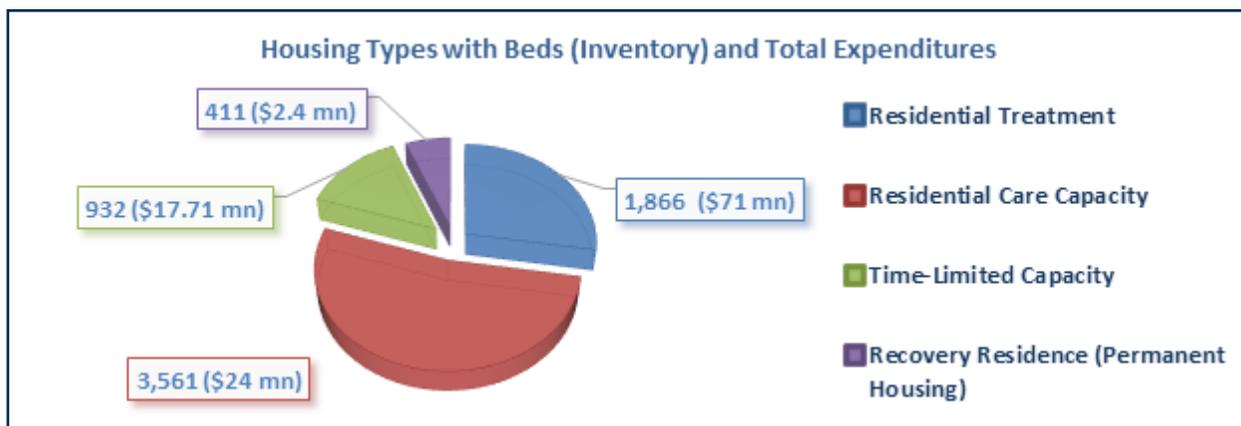


Figure 1: Inventory of Beds by Housing Type and Total Board Expenditures  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

**Residential Treatment Setting.**<sup>11</sup> Ohio had a total of 1,866 beds in Residential Treatment. Level IV (Non-Medical Community Residential –AoD; a 24-hour rehabilitation facility) accounted for 59% of the beds in Ohio; followed by Residential Treatment (a certified Type-1 residential facility providing mental health services to one or more adults, children or adolescents), which had about a 39% (38.8%) share in total beds (figure 2). Under Residential Treatment setting, Boards spent a total of \$71.2 million.

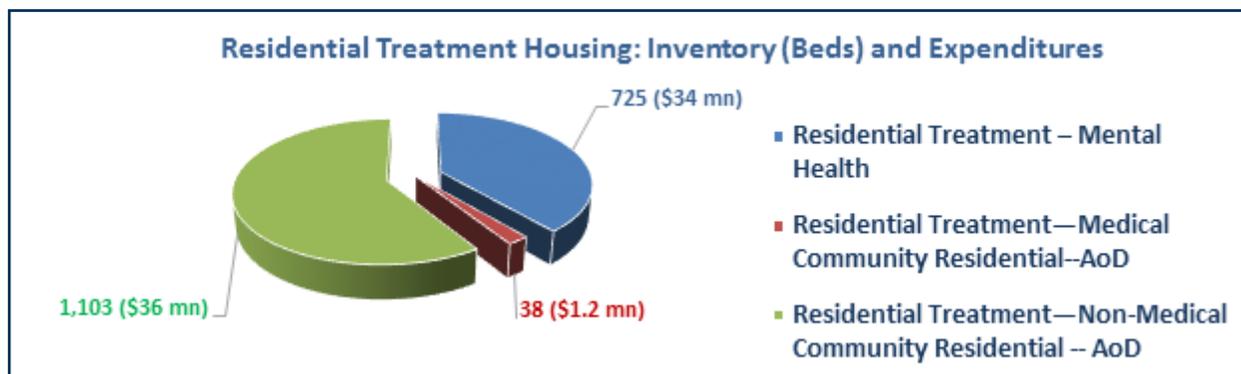
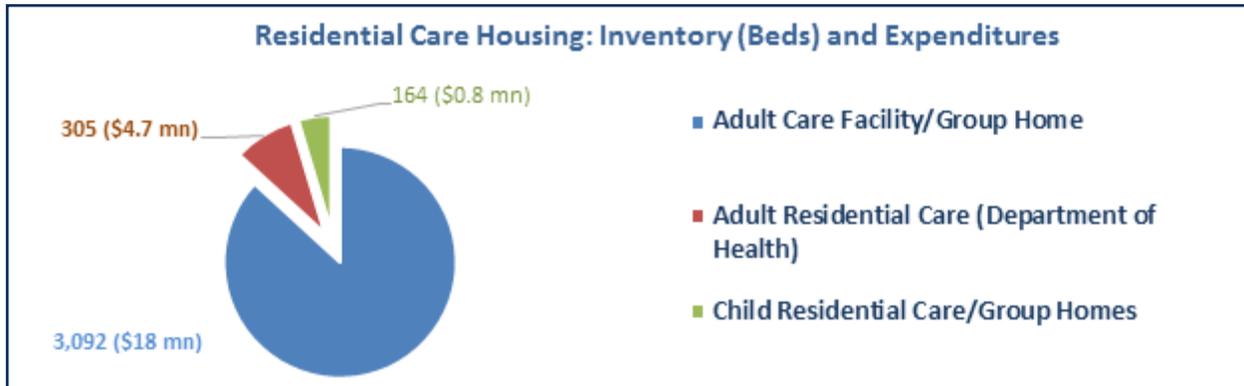


Figure 2: Residential Treatment Housing: Inventory of Beds and Total Board Expenditures  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

<sup>11</sup> This is a licensed 24/7 staffed facility that provides room, board, personal care and clinical services on site as part of the treatment stay; entrance into these facilities is determined by clinical/medical need.

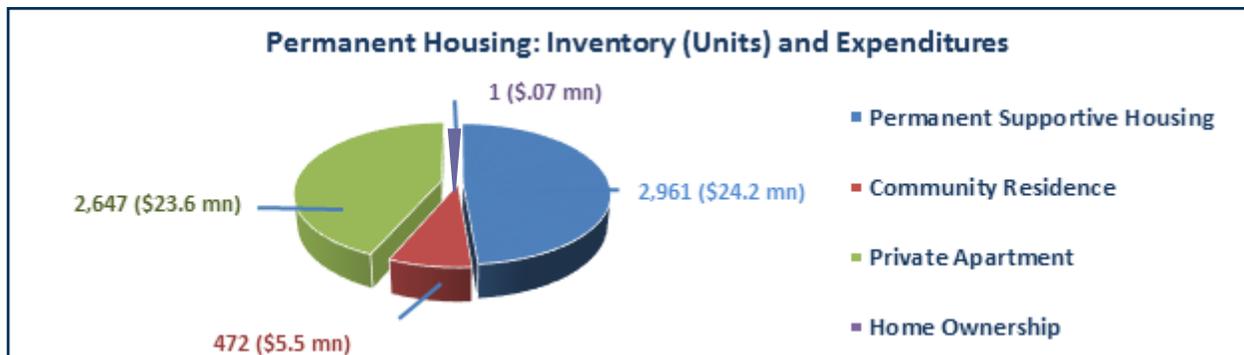
**Residential Care Housing.**<sup>12</sup> Ohio had a total of 3,561 beds for Residential Care with Boards, spending close to \$24 million (figure 3). The spread of these units over four types of residential levels of care (LOC) reveals that Adult Care Facilities (ACF)/Group Homes (state-licensed and providing care to adults) had close to 87% (86.8%) in total beds (figure 3) followed by close to 9% (8.56%) beds under adult Residential Care facility under the Ohio Department of Health (DOH). Child Residential Care/Group Homes (county- or state-licensed and providing care to children or adolescents) had the lowest share in beds (4.6%).



**Figure 3: Residential Care Housing: Inventory of Beds and Total Board Expenditures**  
**Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015**

Note: Licensed DODD (Ohio Department of Developmental Disabilities) Facility not represented in the chart due to “0” values.

**Permanent Housing.**<sup>13</sup> Ohio had a total of 6,081 Permanent Housing units with Board expenditures totaling \$53 million (figure 4). Permanent supportive housing (affordable housing providing a flexible and comprehensive array of supportive services designed to help tenants achieve and sustain housing stability and move toward recovery) had the highest (49%) share; private apartment had 43%; and community residence (Board, provider or privately owned or managed), 8%. Recovery Residence (e.g., Level I, peer-run; Level II, monitored facilities; or Level III, supervised housing) had 411 beds statewide.



**Figure 4: Permanent Housing: Inventory of Beds and Total Board Expenditures**  
**Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015**

**Notes:** 1. Slice of home ownership does not appear in the pie chart due to low number (n=1; \$.07 mn).

2. Recovery housing, another type of Permanent Housing, is not included here and is discussed under inventory of beds. It is not included under community residence.

**Time-Limited Temporary Capacity.**<sup>14</sup> Ohio had a total of 932 beds for Time-Limited Temporary capacity with Boards investing about \$18 million (figure 5). Of the five types of housing within this capacity setting, transitional category (a program with a completion time frame) had close to 45% and crisis care (24/7 staffed, short-term care to stabilize someone experiencing a psychiatric emergency; offered as an alternative to inpatient psychiatric unit) comprised about 25% proportionate share in total beds.

<sup>12</sup> Residential care is a licensed living setting that includes room, board, and personal care; has 24/7 staffing and provides assistance with activities of daily living. Reasons for this level of care are more environmental in nature than psychiatric-based.

<sup>13</sup> Permanent housing are those that do not have any time limits for the lease or resident agreement; apartments may be a scattered site, or a larger housing complex that is in the community of the individuals’ choice; services and supports are not a mandatory component of the housing

<sup>14</sup> Time-limited temporary is a short term or non-permanent setting that can include room, board, and personal care. Such settings provide needed support to residents to return to previous housing setting or to move into a more permanent housing setting or a break from current housing. Treatment and/or services are part of facility rules; and program rules include length of stay.

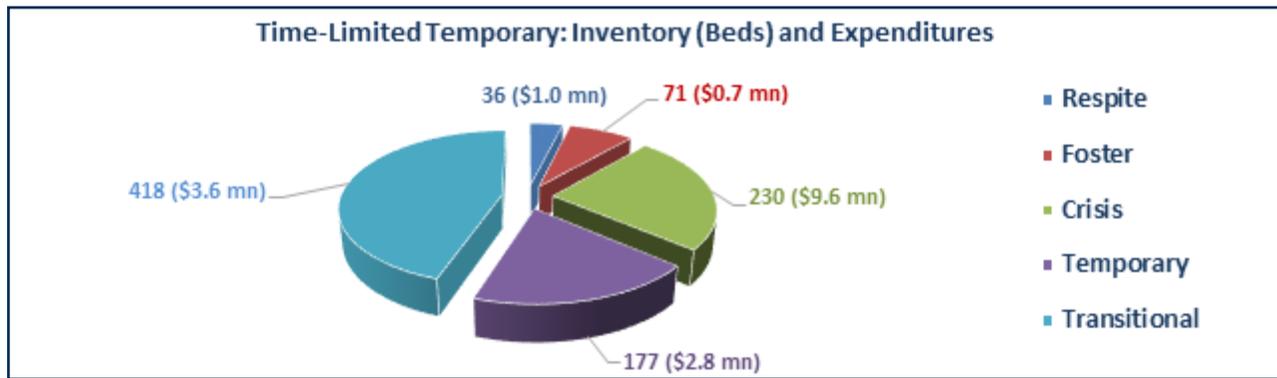


Figure 5: Time-Limited Temporary: Inventory of Beds and Total Board Expenditures  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

### Current Expenditures

Board's SFY 2014 expenditures reveal significant variations and patterns (figures 3-6; and Appendix A). Of the total of \$71.2 million in the Residential Treatment category, Boards spent close to \$36 million on Residential Treatment (Level IV) non-medical community residential (AoD), close to \$34 million on Residential Treatment, and a little more than \$1 million on Residential Treatment (Level IV) medical community residential (figure 6). Analyzed in terms of types of expenditures, Boards spend the most on operations. For example, operations accounted for 57% (\$21 million) of close to \$36 million spent under the Level IV Non-Medical Community Residential category. Similarly, operations took 67% of \$34 million in expenditures under Residential Treatment. In the Residential Treatment housing setting, the least (less than half a million dollars each) was spent on capital and supports.

Of the total \$24 million that Boards invested in Residential Care, the highest amount (\$18 million) was on ACF/Group Home, followed by close to \$5 million on DOH-licensed Residential Care, less than a million on Child Residential Care/ Group Home and none on facilities licensed by the Ohio Department of Developmental Disabilities facility (figure 7). By expenditure type, operations accounted for most with \$10 million invested on ACF/Group Home and \$4 million on DOH-licensed Residential Care facility. Across all expenditures under Residential Care, capital had the lowest investment (a little more than a quarter million dollars).

In the Permanent Housing category, Boards spent a total of \$53 million with \$24 million going to permanent supportive housing, 38% of which was accounted for by capital expenditures (figure 8). This is in contrast to the Residential Treatment and Residential Care settings where capital was the least spent expenditure category. Boards also spent close to \$24 million on private apartments, of which subsidies accounted for 56%. Community residence (\$5.4 million) and home ownership (\$2.4 million) were the least spent housing categories.

In Time-Limited Temporary, of the total \$18 million the Board spent, the highest expenditure (\$9.6 million) was on crisis care, of which capital expenditures had a 34% (\$3.4 million) share followed by operations at 28% (\$2.7 million) (figure 9). The least amount spent (\$1.1 million) was on supports across all categories within Time-Limited Temporary housing.

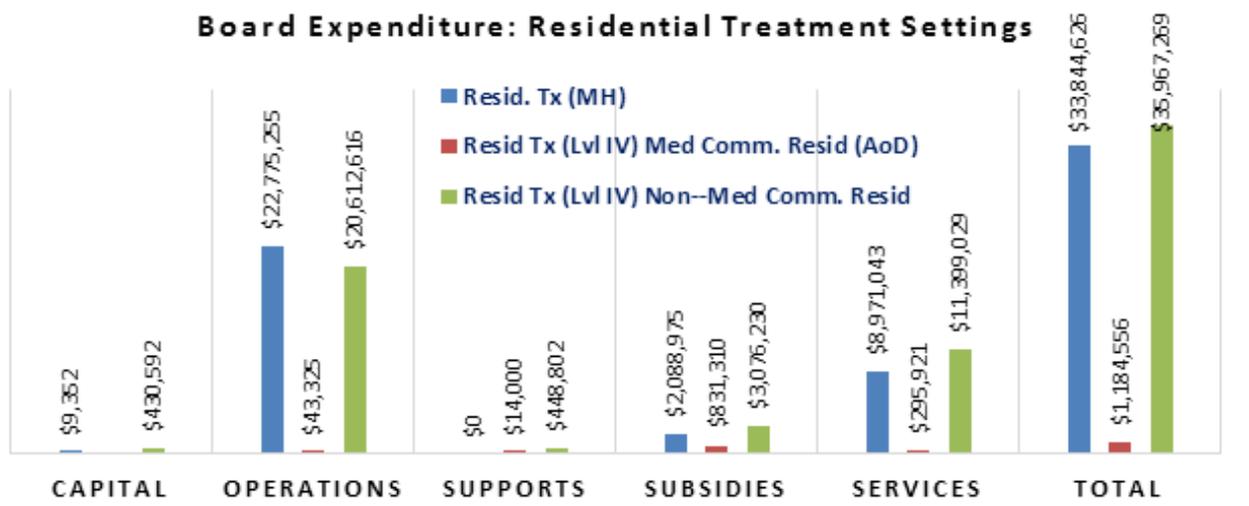


Figure 6: Board SFY 2014 Expenditure Types in Residential Treatment Housing  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

### Board Expenditure: Residential Care Settings

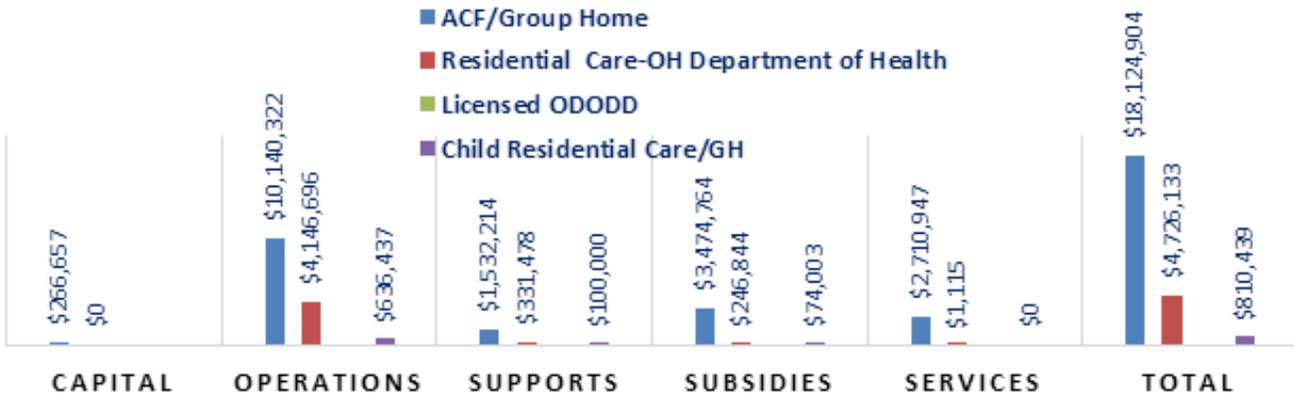


Figure 7: Board SFY 2014 Expenditure Types in Residential Care Housing  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

### Board Expenditure: Permanent Housing Setting

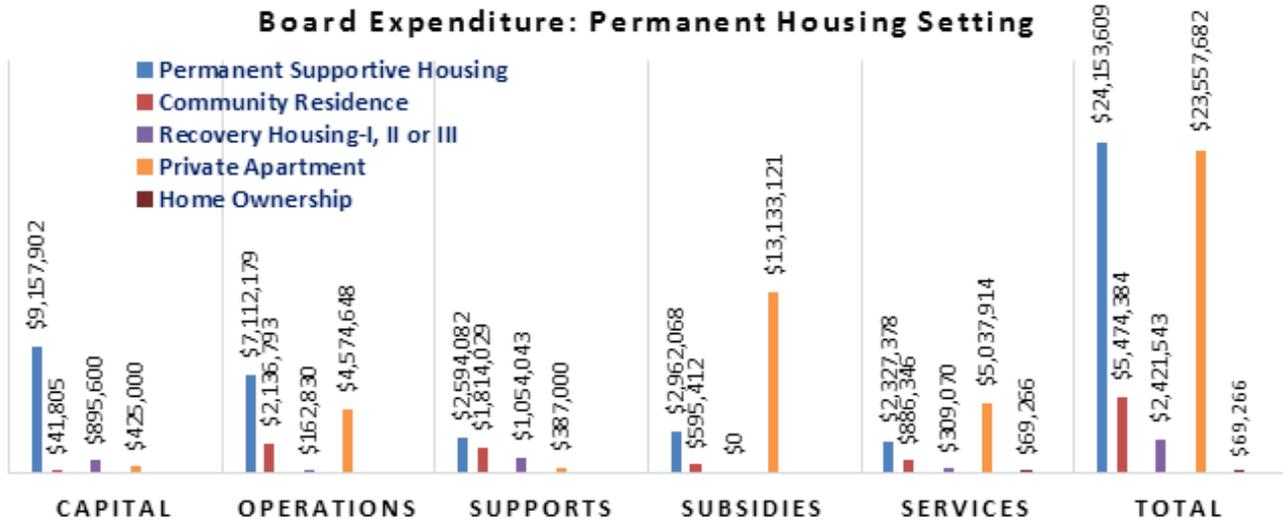


Figure 8: Board SFY 2014 Expenditure Types in Permanent Housing  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

### Board Expenditure: Time-Limited Temporary

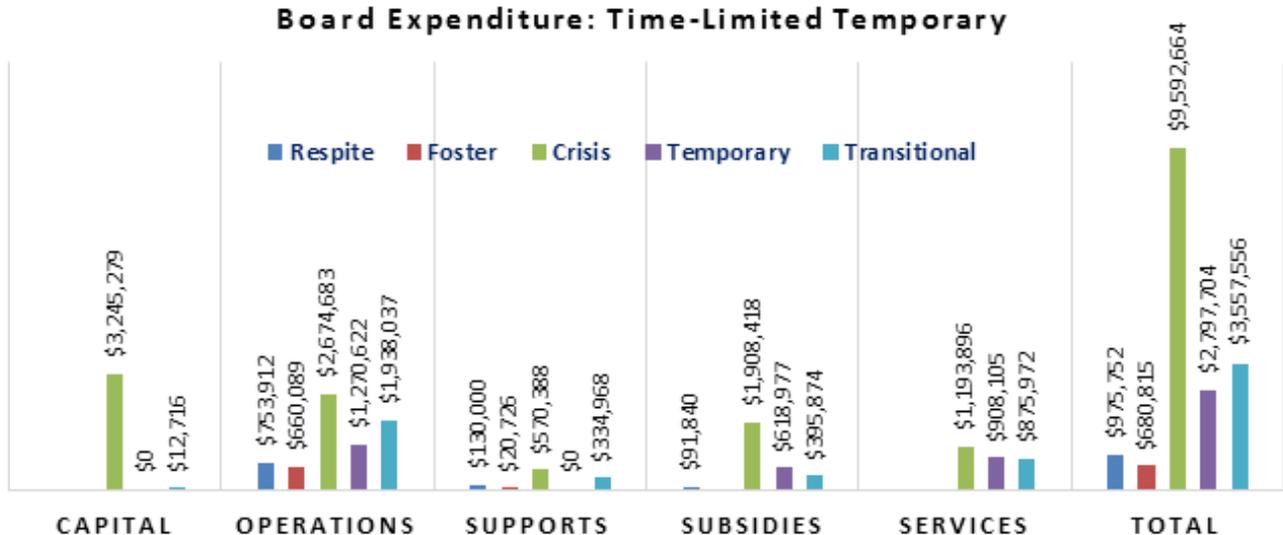


Figure 9: Board SFY 2014 Expenditure Types in Time-Limited Temporary  
Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

## Housing Expenditures across Geographic Entities

Distribution of housing expenditures across geographic entities may offer additional insights on which category of housing gets the highest levels of funding and in which setting. In suburban settings, capital expenditures are the heaviest with close to \$4.2 million going toward Permanent Supportive Housing (figure 10; Appendix B). After capital expenditures, the next highest are in the “service” category with close to \$2.1 million spent on non-medical community residence (Residential Care) and about \$1.6 million on Residential Treatment housing.

However in rural settings, “supports” expenditures are the highest with a little more than \$1 million spent on ACF/Group Home (Residential Care) and close to a million dollars spent on Permanent Supportive Housing (figure 11; Appendix C). Operational expenditures are the next highest in rural area counties with transitional housing setting (Time-Limited Temporary) accounting for about half a million dollars and a little less than that going for Residential Care Facility-Health (Residential Care).

In contrast to suburban and rural settings, operational expenditures dominate the level of spending in metropolitan entities with close to \$20 million on Residential Treatment and about \$19 million on non-medical community residence

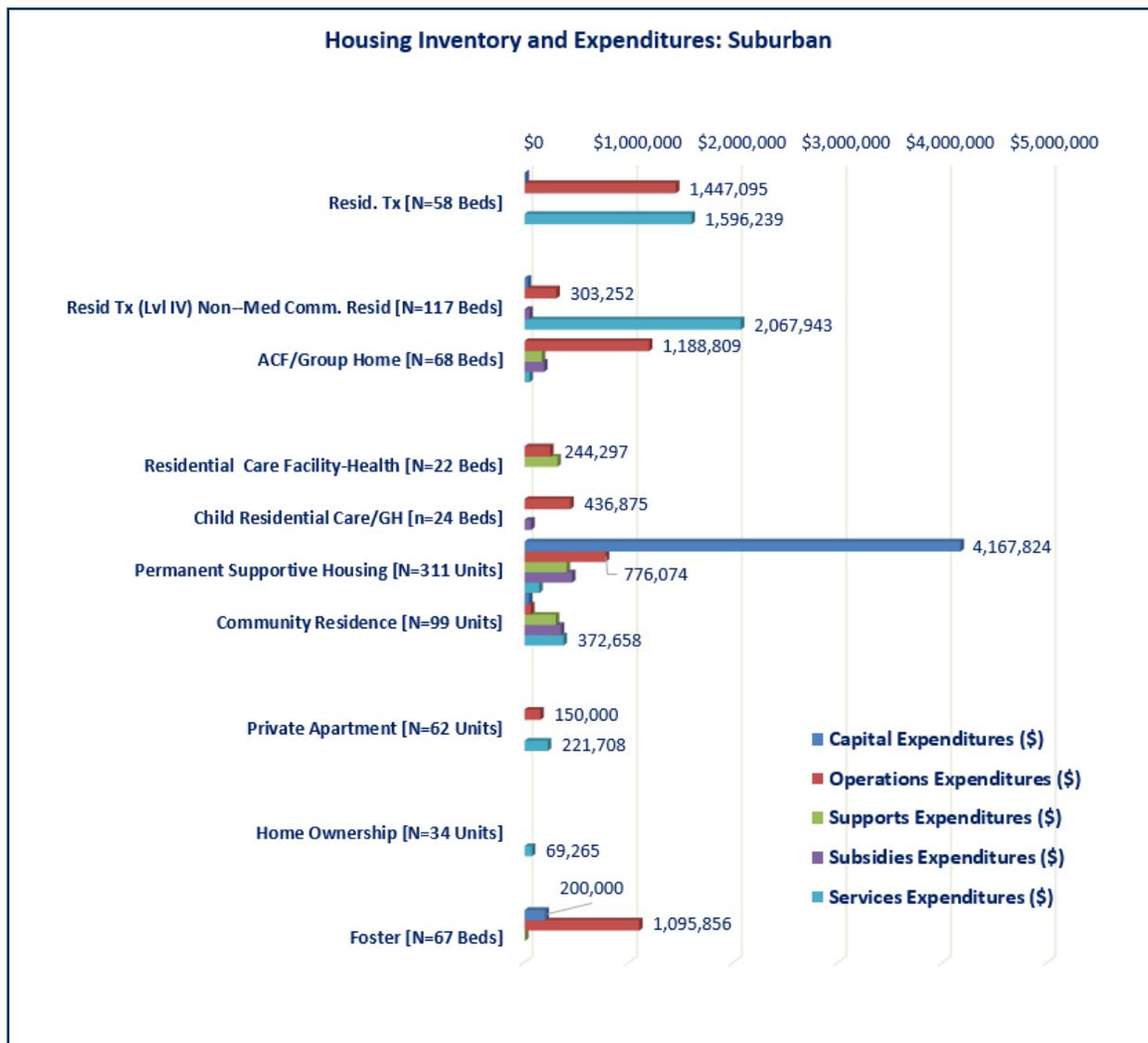


Figure 10: Board SFY 2014 Expenditure Types in Time-Limited Temporary

(Residential Care) (figure 11; Appendix D). One interesting fact is that non-medical community residence also accounted for close to \$9 million as capital expenditures. The next highest level of expenditure for metropolitan setting was subsidies, with \$12 million spent on private apartment (Permanent Housing).

Similar to the suburban setting, the Appalachian capital expenditures are heaviest with close to \$2.4 million going to crisis care (Time-Limited Temporary) which is unique given that crisis care expenditures were not distinct in other settings (figure 12; Appendix E). Operational expenditures were the second highest in Appalachian Counties with close to \$2 million spent on ACF/Group Home (Residential Care).

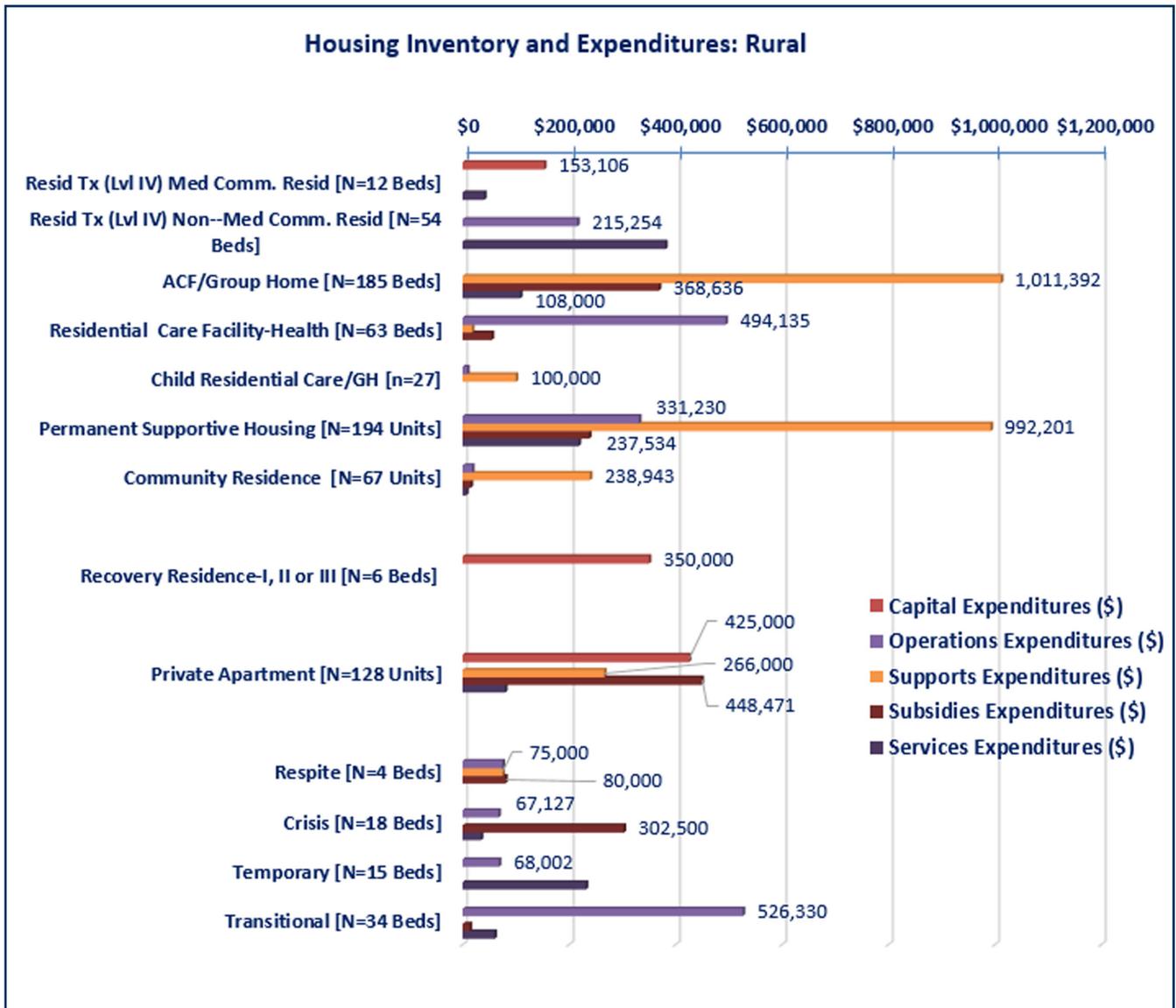
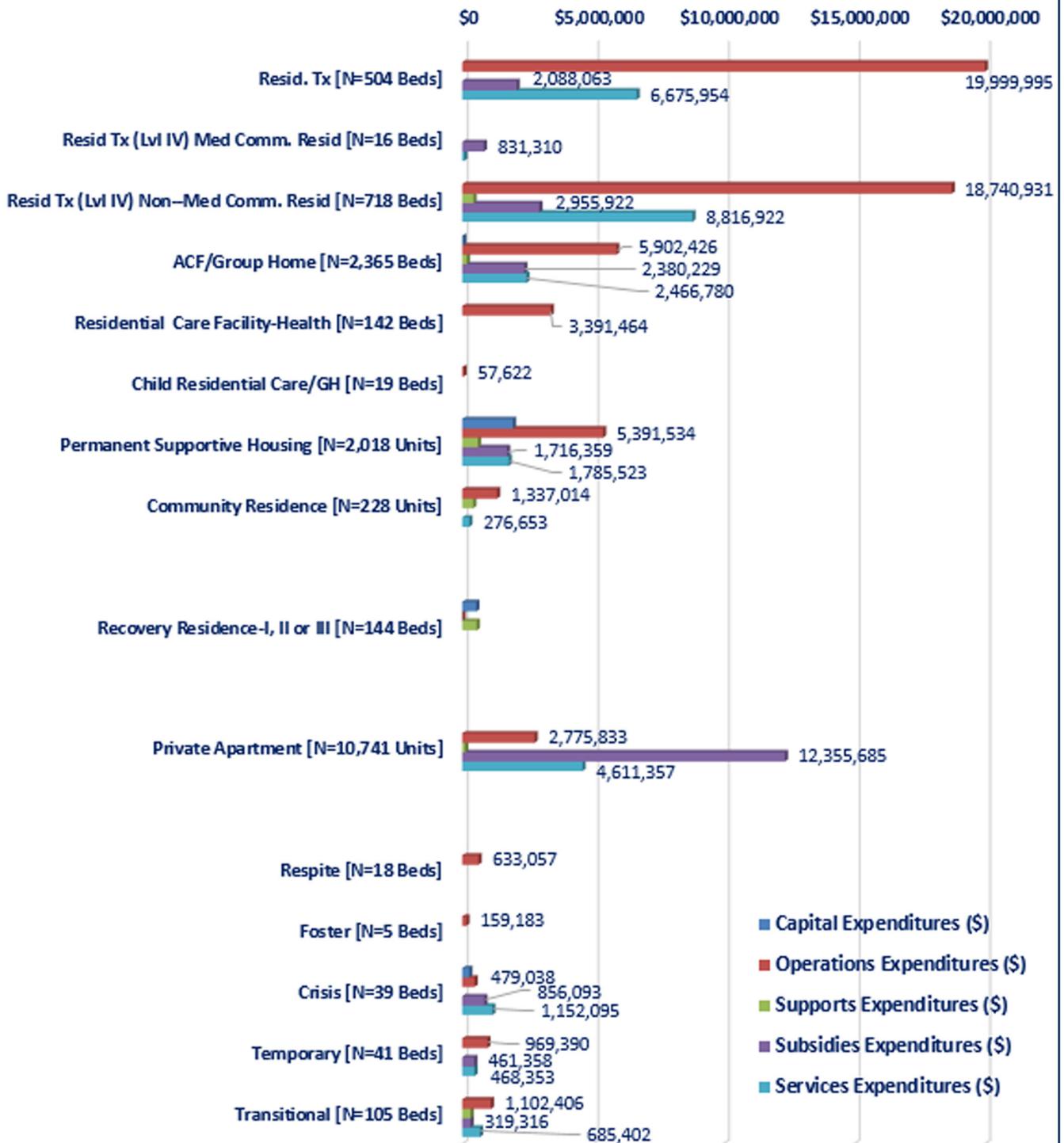


Figure 11: Board SFY 2014 Expenditure Types in Time-Limited Temporary

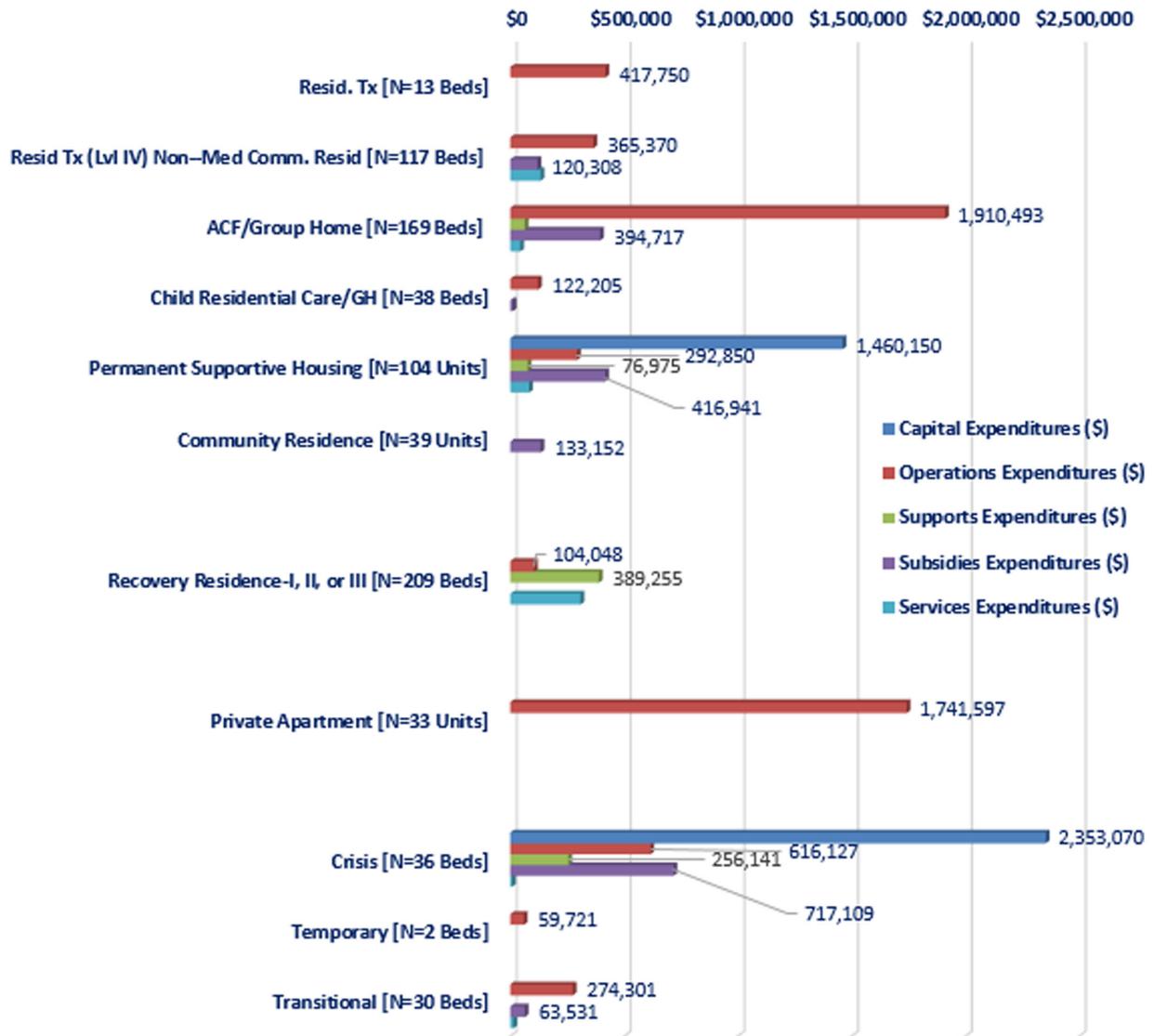
## Housing Inventory and Expenditures: Metropolitan



Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

Figure 12: Board SFY 2014 Expenditure Types in Time-Limited Temporary

### Housing Inventory and Expenditures: Appalachian



Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

Figure 13: Board SFY 2014 Expenditure Types in Time-Limited Temporary

## DISCUSSION

This study sought to investigate the housing inventory and expenditures in the ADAMH, CMH and ADAS Board system. Additional analysis looked at the expenditure pattern across four types of geographic entities, suburban, rural, metropolita, and Appalachian. This section revisits some of the key highlights of the analysis.

**Substance use disorders accounted for 61% of the Residential Treatment beds in Ohio versus 39% for mental health.**

### *Inventory*

In terms of housing beds, Residential Care housing accounted for close to 52% of the total 6,760 beds, followed by Residential Treatment (24%). First, inventory data suggests that a large percent of behavioral health clients are living in Permanent Housing (units) and Residential Care settings (beds). Second, Recovery Residence is gaining prominence as an important type of Permanent Housing. This speaks to the critical role that recovery housing plays in the public behavioral health system.<sup>15</sup> Third, substance use disorders accounted for most (61%) of the Residential Treatment beds in Ohio with Level IV (Non-Medical Community Residential) accounting for 59% and Level II (Medical Community Residential) accounting for 2%. Mental health had about 39% in total beds. Fourth, regarding Residential Care capacity, Adult Care Facility (ACF)/Group Home had close to 87% (86.8%) share in total beds. Fifth, for Time-Limited Temporary capacity, transitional housing had close to 45% (44.8%) in total beds. In the Permanent Housing category, supportive housing (49%) and private apartments (43%) accounted for most of the housing units.

Permanent supportive housing (PSH) is an important strategy in Ohio to meet the unmet housing needs of various clients seeking publicly available behavioral health services. PSH stands on the forefront as one of the effective approaches in behavioral health housing as it combines affordable housing with services to help people overcome complex challenges, such as homelessness, mental illness, physical disabilities, and substance abuse issues.<sup>16</sup> SAMHSA's strategic initiative on "recovery support," emphasizes how Permanent

<sup>15</sup> "Recovery Housing," promotes abstinence from alcohol and other drugs and enhances participation and retention in traditional clinical treatment.

<sup>16</sup> Based on estimates of current placement rates and industry best practices, PSH could strategically reach the following percentage of target population: 95-100% of chronically homeless individuals and families; 32% of ex-offenders with mental illness; and 20% for targeted populations leaving institutional care. PSH has benefited 15 to 20% of runaway and homeless youth. Visit: Corporation of Supportive Housing (CSH). 2014. Meeting the Need: Permanent Supportive Housing Need Assessment & Financial Model for Ohio (October). <http://www.csh.org/2015/02/needs-assessment-and-financial-model-on-supportive-housing-for-ohio/>

Supportive Housing has emerged as a model in which individuals who have mental and substance use disorders can secure stable housing and receive the range of supports they need to manage mental illnesses or other disabilities.<sup>17</sup> OhioMHAS has a long history of assisting local systems in investing in this type of housing going back to Capital Planning funds and the Housing Assistance Program supported by General Revenue Funds in the 1990s.

### *Expenditures*

In terms of housing funding, the state spends the most in the area of operations. A good example of this trend is illustrated in the areas of Residential Treatment and Residential Care. For example, operations took 67% (\$23 million) of \$34 million expenditures in Residential Treatment and 57% (\$21 million) of close to \$36 million in Level IV non-medical community residential. Less than half a million dollars each was spent on capital and supports, which may be a hint that Boards and providers have are perhaps challenged by limited funding sources for bricks and mortar expenditures.<sup>18</sup>

Within the Residential Care setting, operational expenditures accounted for 56% (\$10 million) of the total expenditure on ACF-Group Home and 87% (\$4 million) of the total expenditures on Residential Care supported by the Ohio Department of Health. The least amount spent was on capital for both Residential Treatment (\$.4 million) and Residential Care (\$0.3 million). For both "Residential Treatment" and "Residential Care," this conspicuous

**Boards and providers are constrained by limited funding sources to cover bricks and mortar expenditures for Residential Treatment, Residential Care, and Temporary Housing.**

pattern of more spending in operations and less on capital and supports needs to be explored further if it is indicative of a need for funding supports, which are not covered by Medicaid. There is more capital funding

available for permanent supportive housing than that for Residential Treatment or Residential Care. Nationally, Permanent Supportive Housing aligns with Olmstead, lower operating costs, and federal and state supports for brick and mortar. HUD (US Department of Housing and

<sup>17</sup> SAMHSA states that supportive housing decreases symptoms, increases housing stability, and is cost effective and that for many in recovery from substance use disorders short term drug-free housing may be essential to achieving long-term recovery. Read: US DHHS, SAMHSA. Leading Change: A plan for SAMHSA's Roles and Actions. Visit: <http://store.samhsa.gov/shin/content/SMA11-4629/06-RecoverySupport.pdf>. Accessed on August 17, 2015.

<sup>18</sup> One nonprofit agency has endeavored to: provide quality affordable housing by linking residents to resources that will enable them to stabilize their housing; and move residents beyond poverty where possible. Information available at: [http://www.occh.org/publications/2012\\_CPO\\_Impact\\_Insert.pdf](http://www.occh.org/publications/2012_CPO_Impact_Insert.pdf). Accessed on September 11, 2015.

Urban Development) subsidies cover most operational cost, such costs would appear less for permanent supportive housing. In Ohio, Boards have been paying for operations on Residential Treatment (mental health) given that Medicaid does not cover such expenses. As for Residential Care, although General Revenue Fund (GRF) funds through Residential State Systems covers operating costs, Boards also invest monies to cover such costs.

In terms of funding, the pattern of expenditure for Permanent Housing and Time-Limited Temporary provides a different dimension to where the Boards spend the most and the least. While the Boards spent the least on capital expenditures for Residential Treatment and Residential Care, they had higher levels of capital investments for Permanent Housing and Time-Limited settings. Capital disbursements accounted for 38% (\$9 million) of the \$24 million in the permanent supportive

**Permanent housing was a critical area with capital expenditures of \$9M and \$13M of subsidies.**

housing (PSH); and 34% (\$3 million) of close to \$16 million in crisis care (Time-Limited Temporary). Another finding under Permanent Housing was the expenditure

in subsidies which accounted for 56% (\$13 million) of the close to \$24 million spent on private apartments. Under Time-Limited Temporary setting, noteworthy expenditures were on operations (\$2.7 million) and subsidies (\$1.9 million) for crisis care; and operations (\$1.9 million) for transitional care. While these may appear to be as expected, future analyses may look into whether or not something is being billed through other channels, i.e., Medicaid and other sources.

### **OhioMHAS: Select Critical Housing Initiatives**

In Ohio, the merger of alcohol, drug addiction and mental health agencies, and increased legislative funding has led to building the robust housing plan for individuals recovering from substance use disorders. OhioMHAS has pursued three critical housing initiatives, services and supports.<sup>19</sup>

First, the ACF/AFoH (Adult Care Facility/Adult Foster Home) Incentive Program provides a cash supplement to ACF and AFoH operators who facilitate the linkage of the homes' residents with local mental health and/or substance use disorder providers according to their service needs. This is designed to improve behavioral and physical health outcomes for residents by incentivizing utilization of community resources while increasing revenue for home operators. The second initiative, Recovery Housing, is a safe and healthy living environment that promotes abstinence from alcohol and other drugs and enhances participation and retention

<sup>19</sup> <http://mha.ohio.gov/Default.aspx?tabid=201>

in traditional clinical treatment. In this setting, residents benefit from peer support and accountability, and gain valuable relapse prevention, case management and employment skills training as they transition to living independently and productively in the community. The third initiative is the Residential State Supplement (RSS) Program, Ohio's Optional State Supplementation program, which provides financial assistance to adults who have increased needs due to a disability that is not severe enough to require long term care in an institution, such as a nursing home or hospital.<sup>20</sup>

**Recovery Housing, promotes abstinence from alcohol and other drugs and enhances participation and retention in traditional clinical treatment.**

## **CONCLUSION & POLICY IMPLICATIONS**

Some policy implications are discernible against the backdrop of current housing in Ohio and federal initiatives.

### **Inventory & Expenditures**

- Substance use disorders accounted for three-fifths of the Residential Treatment beds in Ohio with the rest in mental health settings. A 2014 report from the Corporation for Supportive Housing (CSH) and the National Council for Behavioral Health provides three recommendations for a comprehensive continuum of housing and services to promote long-term recovery among individuals with substance use disorders: (1) system change that promotes integration of housing, treatment and recovery support systems at the federal, state and local levels; (2) cultivating and disseminating knowledge by building an evidence base around housing models and best practices for serving individuals/families with substance use disorders and by working with partners to disseminate knowledge broadly; and (3) improving practice by building the capacity of supportive housing and recovery housing providers to integrate best practices at the nexus of housing and services for individuals with substance use disorders.<sup>21</sup>
- Inventory-wise, a large percent of the behavioral health clients are living in Permanent Housing (units) and Residential Care (beds) settings. Recovery Residence is increasingly playing a strategic role in the housing continuum of care because it provides

<sup>20</sup> Individuals use RSS, which supplements their income, to pay the monthly allowable fee (or "rent") for accommodations, supervision, and personal care services at eligible living arrangements in the community.

<sup>21</sup> [http://www.thenationalcouncil.org/wp-content/uploads/2015/09/SUHLF-Convening-Report\\_FINAL.pdf](http://www.thenationalcouncil.org/wp-content/uploads/2015/09/SUHLF-Convening-Report_FINAL.pdf)

a supportive, structured and recovery-oriented environment.<sup>22</sup> Behavioral health systems more than ever are recognizing that safe and affordable housing in the community is a foundational component of recovery for people with substance use disorders.<sup>23</sup> Consequently, OhioMHAS SFY 2016-17 budget invests an additional \$2.5 million annually in recovery housing over the next two years in addition to the \$10 million already allocated in the 2015 Mid-Biennium Review.<sup>24</sup>

- One emergent housing trend in Ohio relates to community-based services that are designed to support long-term recovery from mental illness. Ohio has been seeing a growing shift from nursing-based facility care to Home and Community-Based Services (HCBS). HCBS arguably provides tremendous cost savings in dual (Medicare and Medicaid) settings, an area that has profound implications for housing funding allocations moving forward.<sup>25</sup> In Ohio, House Bill 64 (effective July 1, 2015) prioritizes HCBS as one of the top ten health transformation initiatives in the budget; intended to increase access to affordable housing as a strategy to avoid unnecessary institutional placements.<sup>26</sup>
- It would be worthwhile here to make a reference to the patient-centered medical home (PCMH).<sup>27</sup> In December 2014, Ohio was awarded a federal State Innovation Model test grant to implement a payment model that increases access to PCMHs statewide. PCMH is a team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs with an emphasis

on health care value and quality.

- Ohio's housing environment would benefit from various federal government initiatives. Currently, Ohio is engaged in Money Follows the Person (MFP), a federal grant program that helps states rebalance their Medicaid long-term care systems by increasing the use of HCBS and reducing institutionally based services.<sup>28</sup> In 2011, the Centers for Medicare & Medicaid Services also announced a total award of nearly \$2 million in Real Choice Systems Change grants to six states to support the development of partnerships with state housing agencies. The grants aim to advance strategies to provide permanent and affordable rental housing for people with disabilities who are homeless and also participants in the MFP demonstration program.<sup>29</sup>
- Homeless housing is another area Ohio has pursued strategically in alignment with federally funded programs like SAMHSA's Projects for Assistance in Transition from Homelessness (PATH).<sup>30</sup>
- Another study points to the overall lack of affordable housing, especially in areas that are safe, accessible and supportive to a person's wellbeing; and reflects on how persons with mental illnesses and addiction disorders are forced to compete with the general population for very scarce resources.<sup>31</sup>

### **Geographic Settings: Funding Scenario**

- Funding categories by geographic settings provide further insights. Capital expenditures were the highest for suburban and Appalachian settings (Table 1 - next page). The difference was that for the suburban setting, capital expenditures went to permanent supportive housing, whereas for the Appalachian setting, capital expenditures were on crisis care, which was unique in contrast to other geographic entities.
- In the rural county boards, supports expenditures were the highest with resources going toward

22 One 2013 report, in its review of research lend support to the fact that recovery housing positively impacts total quality of life including gains in employment, increased family and social functioning, improved psychological and emotional well-being, decreased substance use, and reduced criminal activity. Read: Ohio Council of Behavioral Health & Family Services Providers. 2013. Recovery Housing in the State of Ohio: Findings and Recommendations from an Environmental Scan. Available at: <https://obc.memberclicks.net/assets/OHRecoveryHousing/ohiorecoveryhousingjune2013%20final.pdf>. Accessed August 16th 2015

23 CSH and National Council for Behavioral Health. 2014. Substance Use and Housing National Leadership Forum Convening Report. Washington DC (October 6-7). Visit: [http://www.thenationalcouncil.org/wp-content/uploads/2015/09/SUHLF-Convening-Report\\_FINAL.pdf](http://www.thenationalcouncil.org/wp-content/uploads/2015/09/SUHLF-Convening-Report_FINAL.pdf). Accessed on December 12, 2015.

24 OhioMHAS in-house document: OhioMHAS SFY 16-17 Budget Highlights. Available at: <http://mha.ohio.gov/Portals/0/assets/News/Legislation/Budget/SFY16-17-OhioMHAS-budget-highlights-FINAL.pdf>. Accessed on December 15, 2015.

25 Ohio has been argued to surpass a goal of using at least 50% of the Medicaid long-term care budget and community based services as the percentage of spending in nursing and institutional care has fallen to new lows. Read The Columbus Dispatch, 2014. Ohio Reduces Spending on Nursing Homes. Columbus (September 11). Available at: <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=PBDWCq2Yto%3d&tabid=70>. Accessed on December 14, 2015. <http://www.dispatch.com/content/stories/local/2014/09/11/spending-on-nursing-homes-falls.html>. Accessed on December 14, 2015.

26 Ohio Governor's Office of Health Transformation (OHT). Available at: [http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=NRBESTA1\\_3E%3d&tabid=136](http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=NRBESTA1_3E%3d&tabid=136). Accessed on December 15, 2015.

27 Visit: <http://www.healthtransformation.ohio.gov/CurrentInitiatives/EncouragePatientCenteredMedicalHomes.aspx>. Accessed on December 15, 2015

28 <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html>. The Money Follows the Person (MFP) Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems. Over 40,500 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs as of December 2013.

29 [http://www.allhealth.org/publications/Disparities\\_in\\_health\\_care/Health-and-Housing-Toolkit\\_168.pdf](http://www.allhealth.org/publications/Disparities_in_health_care/Health-and-Housing-Toolkit_168.pdf). Accessed on December 12, 2015.

30 One evaluative study found the integrated health & housing services to be a feasible model for the provision of supportive services to formerly homeless tenants; given the higher utilization rates for on-site services, especially for primary care and MH services; decline in utilization of hospital ER; and reportedly higher residential stability. Read: Lenior, G. 2000. The Network: Health, Housing and Integrated Services: Best Practices and Lessons Learned. Corporation for Supportive Housing. New York.

31 The Behavioral Health Network of Greater St. Louis. 2012. Behavioral Health Network 2011 Housing Needs Assessment and Resource Inventory. Available at: <http://www.bhnstl.org/wp-content/uploads/2010/11/BHN-Housing-Needs-Assessment-Resource-Inventory-MARCH-FINAL.pdf>. Accessed on August 13, 2015.

**Table 1. Highest Expenditure Categories: Geographic Settings**

	Highest Expenditure Category #1	Highest Expenditure Category #2
<b>Suburban</b>	“Capital” Expenditures [Permanent Supportive Housing]	“Service” Expenditures [Non-Med Community Residence]
<b>Rural</b>	“Supports” Expenditures [ACF/Group Home]	“Operations” Expenditures [Transitional Housing]
<b>Metropolitan</b>	“Operations” Expenditures [Residential Treatment]	“Subsidies” Funding [Private Apartment]
<b>Appalachian</b>	“Capital” Expenditures [Crisis Care]	“Operations” Expenditures [ACF/Group Home]

ACF/Group Home (Residential Care). The second highest expenditures were operational which was for transitional housing. As for Appalachian county Boards, capital expenditures were heaviest with the resources directed towards crisis care. Accordingly, there is a need for investment in Time-Limited Temporary housing in rural and Appalachian counties.

**Future Directions**

Future analyses could look at cost implications of health and housing initiatives in Ohio. For example, the Alliance for Health Reform Toolkit (2015) makes reference to two cost-benefit studies.<sup>32</sup> One study argues that cost-benefit studies have shown that supportive housing for particular populations can generate significant savings.<sup>33</sup> The other study indicates that a Medicaid supportive housing benefit would be cost effective looking only at medical and behavioral health expenditures, while also providing broader community benefits in quality of life for the high need individuals and savings in criminal justice costs.<sup>34</sup>

32 [http://www.allhealth.org/publications/Disparities\\_in\\_health\\_care/Health-and-Housing-Toolkit\\_168.pdf](http://www.allhealth.org/publications/Disparities_in_health_care/Health-and-Housing-Toolkit_168.pdf). Accessed on December 12, 2015.

33 Perlman, Jennifer and Parvensky, John. “Denver First Housing Collaborative: Cost Benefit Analysis and Program Outcomes report” Colorado Coalition for the Homeless; and Denver’s Road Home. December 2006. <http://goo.gl/b3WTXJ>

34 Larimer, M., Malone, D., Garner, M. et al. “Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems.” Journal of the American Medical Association April 1, 2009. <http://goo.gl/mONQgT>.

**APPENDIX A**  
**BOARDS' SFY 2014 EXPENDITURES BY TYPES OF HOUSING AND FUNDING SOURCES [STATEWIDE]**

**Table 2. Statewide Expenditure Categories.**

SFY 2014 Expenditures by Housing & Types [Units or Beds, as specified]		STATEWIDE EXPENDITURES (\$)					Total Expenditures
		Capital	Operations	Supports	Subsidies	Services	
Residential Treatment	Resid. Tx	9,352.0	22,775,255.4		2,088,975.3	8,971,043.5	33,844,626.1
	Resid Tx (Lvl IV) Med. Comm. Resid		43,325.0	14,000.0	831,310.0	295,921.0	1,184,556.0
	Resid Tx (Lvl IV) Non--Med Comm. Resid	430,592.0	20,612,616.0	448,802.0	3,076,230.1	11,399,029.2	35,967,269.3
Residential Care	ACF/Group Home	266,656.8	10,140,321.5	1,532,214.0	3,474,764.4	2,710,947.2	18,124,903.9
	Residential Care Facility-Health		4,146,696.0	331,478.0	246,843.8	1,115.0	4,726,132.8
	Licensed ODODD						- 0 -
	Child Residential Care/GH		636,436.7	100,000.0	74,002.7		810,439.4
Permanent Housing	Permanent Supportive Housing	9,157,902.0	7,112,178.9	2,594,082.4	2,962,068.3	2,327,377.7	24,153,609.3
	Community Residence	41,805.0	2,136,792.8	1,814,029.0	595,412.0	886,345.6	5,474,384.4
	Recovery Residence-I or II	895,600.0	162,830.0	1,054,043.0		309,070.4	2,421,543.4
	Private Apartment	425,000.0	4,574,648.1	387,000.0	13,133,120.6	5,037,913.6	23,557,682.2
	Home Ownership					69,265.6	69,265.6
Time-Limited Temporary	Respite		753,912.0	130,000.0	91,840.0		975,752.0
	Foster		660,089.0	20,726.0			680,815.0
	Crisis	3,245,278.5	2,674,682.8	570,388.1	1,908,418.0	1,193,896.2	9,592,663.6
	Temporary		1,270,622.0		618,977.0	908,105.0	2,797,704.0
	Transitional	12,716.0	1,938,036.9	334,967.9	395,873.6	875,972.0	3,557,556.3
<b>Total Expenditures by Column</b>		<b>14,484,902.4</b>	<b>79,638,443.0</b>	<b>9,317,730.3</b>	<b>29,542,735.7</b>	<b>34,986,001.9</b>	

Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

**APPENDIX B**  
**BOARDS SFY 2014 EXPENDITURES BY TYPES OF HOUSING AND FUNDING SOURCES [SUBURBAN]**

**Table 3. Suburban Expenditure Categories.**

SFY 2014 Expenditures by Housing & Types [Units or Beds, as specified]		SUBURBAN EXPENDITURES (\$)					Total Expenditures
		Capital	Operations	Supports	Subsidies	Services	
Residential Treatment [Beds]	Resid. Tx [N=58 Beds]	9,352	1,447,095			1,596,239	3,052,686
	Resid Tx (Lvl IV) Non--Med Comm. Resid [N=117 Beds]	30,592	303,252		45,900	2,067,943	2,447,687
Residential Care [Beds]	ACF/Group Home [N=68]		1,188,809	165,310	186,215	46,449	1,586,783
	Residential Care Facility-Health [N=22 Beds]		244,297	314,000			558,297
	Child Residential Care/GH [n=24 Beds]		436,875		63,160		500,035
Permanent Housing [Units]	Permanent Supportive Housing [N=311 Units]	4,167,824	776,074	402,047	454,189	141,391	5,941,525
	Community Residence [N=99 Units]	41,805	61,000	298,300	347,260	372,658	1,121,023
	Private Apartment [N=62 Units]		150,000			221,708	371,708
	Home Ownership [N=34 Units]					69,265	69,265
	Foster [N=67 Units]	200,000	1,095,856	5,068			1,300,924
<b>Total Expenditures by Column</b>		<b>4,449,573</b>	<b>5,703,258</b>	<b>1,184,725</b>	<b>1,096,724</b>	<b>4,515,653</b>	<b>16,949,933</b>

Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

- Disclaimers: 1. Analysis excludes those that only had beds and units reported but no expenses.  
2. Licensed ODODD (Residential Care) not included due to zero expense reporting.

**APPENDIX C**  
**BOARDS SFY 2014 EXPENDITURES BY TYPES OF HOUSING AND FUNDING SOURCES [RURAL]**

**Table 4. Rural Expenditure Categories.**

SFY 2014 Expenditures by Housing & Types [Units or Beds, as specified]		RURAL EXPENDITURES (\$)					Total Expenditures
		Capital	Operations	Supports	Subsidies	Services	
Residential Treatment [Beds]	Resid Tx (Lvl IV) Med. Comm. Resid [N=12]	153,106				40,347	193,453
	Resid Tx (Lvl IV) Non--Med Comm. Resid [N=54]		215,254			380,704	595,958
Residential Care	ACF/Group Home [N=185]			1,011,392	368,636	108,000	1,488,028
	Residential Care Facility-Health [N=63]		494,135	17,478	54,572		566,185
	Child Residential Care/GH [N=27]		8,550	100,000			108,550
Permanent Housing	Permanent Supportive Housing [N=194]		331,230	992,201	237,534	217,991	1,778,956
	Community Residence [N=67]		17,755	238,943	15,000	6,481	256,359
	Recovery Residence-I or II [Beds] [N=6]	350,000					350,000
	Private Apartment [N=128]	425,000		266,000	448,471	79,580	1,219,051
Time-Limited Temporary	Respite [N=4]		75,000	75,000	80,000		230,000
	Crisis [N=18]		67,127		302,500	34,347	403,974
	Temporary [N=15]		68,002			231,264	299,266
	Transitional [N=34]		526,330		13,027	60,000	599,357
<b>Total Expenditures by Column</b>		<b>928,106</b>	<b>1,803,383</b>	<b>2,701,014</b>	<b>1519740</b>	<b>1,158,714</b>	

Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

- Disclaimers: 1. Analysis excludes those that only had beds and units reported but no expenses.  
2. Licensed ODOOD (Residential Care) not included due to zero expense reporting.

**APPENDIX D**  
**BOARDS SFY 2014 EXPENDITURES BY TYPES OF HOUSING AND FUNDING SOURCES [METROPOLITAN]**

**Table 5. Metropolitan Expenditure Categories.**

SFY 2014 Expenditures by Housing & Types [Units or Beds, as specified]		METROPOLITAN EXPENDITURES (\$)					Total Expenditures
		Capital	Operations	Supports	Subsidies	Services	
Residential Treatment	Resid. Tx		19,999,995		2,088,063	6,675,954	26,678,037
	Resid Tx (Lvl IV) Med. Comm. Resid [16 Beds]				831,310	85,574	916,884
	Resid Tx (Lvl IV) Non--Med Comm. Resid [718 Beds]		18,740,931	434,802	2,955,922	8,816,922	30,988,577
Residential Care	ACF/Group Home [2,365 Beds]	41,656	5,902,426	177,065	2,380,229	2,466,780	10,968,156
	Residential Care Facility-Health [142 Beds]		3,391,464				3,391,464
	Child Residential Care/GH [19 Beds]		57,622				57,622
Permanent Housing	Permanent Supportive Housing [2,018 Units]	1,944,928	5,391,534	605,860	1,716,359	1,785,523	6,444,204
	Community Residence [228 Units]		1,337,014	428,565		276,653	2,042,232
	Recovery Residence-I, II or III [144 Beds]	545,600	10,300	563,627			1,120,527
	Private Apartment [10,741 Units]		2,775,833	121,000	12,355,685	4,611,357	19,863,875
Time-Limited Temporary	Respite [18 Beds]		633,057				633,057
	Foster [5 Beds]		159,183				159,183
	Crisis [39 Beds]	275,000	479,038		856,093	1,152,095	2,762,226
	Temporary [41 Beds]		969,390		461,358	468,353	1,899,101
	Transitional [105 Beds]		1,102,406	324,967	319,316	685,402	2,432,091
<b>Total Expenditures by Column</b>		<b>2,807,184</b>	<b>60,950,193</b>	<b>2,496,586</b>	<b>23,964,335</b>	<b>27,024,613</b>	

Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

- Disclaimers: 1. Analysis excludes those that only had beds and units reported but no expenses.  
2. Licensed ODODD (Residential Care) not included due to zero expense reporting.

**APPENDIX E**  
**BOARDS SFY 2014 EXPENDITURES BY TYPES OF HOUSING AND FUNDING SOURCES [APPALACHIA]**

**Table 6. Appalachia Expenditure Categories.**

SFY 2014 Expenditures by Housing & Types [Units or Beds, as specified]		APPALACHIA EXPENDITURES (\$)					Total Expenditures
		Capital	Operations	Supports	Subsidies	Services	
Residential Treatment	Resid. Tx [13 Beds]		417,750				417,750
	Resid Tx (Lvl IV) Non--Med Comm. Resid [N=117]		365,370		120,308	132,764	619,442
Residential Care	ACF/Group Home [169 Beds]		1,910,493	63,446	394,717	43,625	2,412,281
	Child Residential Care/ GH [38 Beds]		122,205		10,843		133,048
Permanent Housing	Permanent Supportive Housing [104 Units]	1,460,150	292,850	76,975	416,941	82,776	2,329,692
	Community Residence [39 Units]				133,152		133,152
	Recovery Residence-I, II or III [209 Beds]		104,048	389,255		309,070	802,373
	Private Apartment [33 Units]		1,741,597				1,741,597
Time-Limited Temporary	Crisis [36 Beds]			256,141	717,109	7,457	3,949,904
	Temporary [2 Beds]						59,721
	Transitional [30 Beds]				63,531	13,777	351,609
<b>Total Expenditures by Column</b>		<b>3,813,220</b>	<b>5,904,462</b>	<b>785,817</b>	<b>2,535,418</b>	<b>589,469</b>	

Source: Ohio Behavioral Health Housing Needs Assessment Survey 2015

- Disclaimers: 1. Analysis excludes those that only had beds and units reported but no expenses.  
2. Licensed ODODD (Residential Care) not included due to zero expense reporting.

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